sigmoid and then it is the sigmoid with its many turns and bends that is sacculated and impacted. Cathartics aggravate the spasm of a corded colon. Sigmoid impactions usually extend clear across the pelvis and the supposed growths are often figured as intraligamentary. In any case, the rectal sphincters are in a state of spasm and a condition of the rectal veins, resembling hemorrhoids, is very common. Attacks of painful rectal spasm occur by times at night suggesting the rectal crises of locomotor ataxia and are relieved at once by a rectal dilator, the index finger, a movement of the bowels or by getting out of bed and moving about.

While examining the abdominal organs one finds the same marked lack of muscular development in the abdominal walls so often met with in cases of sub-developed exophthalmic goitre. There is usually a separation of the recti while the flat muscles of the abdomen are very thin and in some cases almost wholly wanting. The natural result is a splanchnoptosis—a falling of all the organs in the abdominal cavity. It is in women with this type of abdominal wall, so common in exophthalmic goitre, that we meet labors with tedious, trying second stages, there being practically no abdominal muscles to supply the necessary two-thirds of the power demanded for expulsion of the fetus. It is the same type of woman, when thin as a knife, that gets joyously fat during pregnancy, digestion and assimilation being improved and abdominal tension kept up by the growing uterus pushing the abdominal organs into place and keeping them there for four or five months or more. Within a few months after labor, the support being gone and abdominal tension wanting, these women slip back again into the lank class. The splanchnoptosis, sickheadaches, fecal impactions, hyperchlorhydria, chronic appendicitis, hemorrhoids, hepatic and renal insufficiencies, uricacidemia, the blues, mucomembranous stools and intestinal lithiasis return and the patient becomes more discouraged and hysterical than ever. At this stage she becomes a "Christian scientist," because medical science and medical treatment have failed to make good in her case. I am always tolerant of medical and therapeutic fads, of "Christian scientists," osteopaths, and all such classes because the reason for their existence is based on the failure of the medical profession to furnish the public with the cures asked for. If our profession made good there would be no room for fads or fakes.

This paper up to the present would suggest a dozen different diagnoses and, to put it mildly, that number is small compared with the number made if the patient sees physicians enough; but the disease described here, whether membranes have or have not appeared in the stools, is the same disease that is finally called mucomembranous enterocolitis. It is a constitutional disease, belonging to the degenerations, and the mucomembranous discharges which finally give it a name are but end-products in the fully developed affection. The disease may exist for years before the grade of severity and nervous exhaustion is reached in which intestinal lithiasis, mucus diarrhea and membranous discharges appear. The stress and strain of life have much to do with hurrying the evolution of the symptoms and if this stress and strain be removed in the fully developed disease the membranous discharges disappear, the original diagnosis is forgotten, and the next physician tacks a new label on the case.

The disease is not hereditary but the patient is. She has to pack the type of nervous system and metabolic organs from which sprung the hysterias, neurasthenias, epilepsies, insanities, gouty arthritism, uric acidemias, and gastroenteroptosis of her forbears, and especially so the inadequate liver, renal insufficiency, and feeble musculature of the abdominal wall which are such marked factors in causing and continuing the depressing intestinal toxemias of mucomembranous enterocolitis.

Gentlemen, I had figured on giving a rather full clinical picture of mucomembranous enterocolitis, but have succeeded so far in giving only the leading findings that are usually overlooked, and, even then, not all of these. Having overrun the time limit, I will content myself by saying that the common everyday symptoms, the symptoms by which the disease is usually diagnosed are three, to wit: Coprostasis. intestinal colic, and mucus or mucomembranous stools. Chronic constipation may have existed from childhood; colic in the colon is located above the bladder or in what would be figured the small intestine and this colic is followed by mucomembranous stools. A common sequence is obstipation, colic and mucus diarrhea, the diarrhea and colic being most marked when the constipation is most obstinate. Constipation and diarrhea exist at one and the same time, the diarrhea being due to the coprostasis and to an excess of blood in the abdominal vessels through lack of abdominal tension.

In an acute attack, when the liver fails to secrete bile, the membranous discharges are white and clear as sago. I have seen a night-vase half-filled with these sago-white discharges in twelve hours. Once the liver assumes its functions the mucus and membranous discharges become a dirty yellow. The colic, more or less resistant to codein, may last for hours or days and is best relieved by hot poultices to the abdomen. Once nurse and physician have learned this lesson, the case is easier handled. The rest-cure is of value.

Osteomalacia: Addenda.

I desire to state that now, six weeks subsequent to making the report (page 155, May *Journal*), my patient presents the following symptoms:

Almost constant pain in left femur and back, necessitating the hypodermic administration of ⅜ gr. of morphia once or twice a day, having exhausted all other anodynes. Stomach still rebellious, rejecting fully one-half the nourishment taken.

Abnormal mobility in both femur now quite discernable. The illustration (page 155, May *Journal*) shows the lower third affected, now in both femur, upper third, permitting a considerable rotation of each femur, while the trochanters remain stationary or do not conform to the movements imparted by the shaft of the bone.

The left illiac crest, from the superior spinus process backward, is about double the thickness of that of the right side.

Continued loss of flesh; hope waning, but mind unimpaired.

C. S. STODDARD, M. D.

Cooper College Commencement.

The commencement exercises of Cooper Medical College were held in the college auditorium on Tuesday evening, May 9th. Thirty-seven candidates received the degree. This graduating class entered the college with a membership of ninety-five, but each year the examinations reduced the membership, because the students found unfit were not permitted to obtain advanced standing. Those who were given the degree were, therefore, carefully selected from the number that began their medical studies.

The exercises were held upon what is known in the college as Founder's Day, the birthday of the late Dr. Lane, and attention was called in the addresses of the evening to this fact, and to the life and work of Dr. Lane. Professor Ellinwood made the address to the graduating class on behalf of the faculty. A second address was delivered by Edward R. Taylor, Esq., dean of the Hastings College of Law. He referred to the fact that he had delivered an address to the graduating class of the Medical College of the Pacific thirty-two years ago, and that the present faculty contained but three of the members of the faculty present at that time—Drs. Barkan, Gibbons and Ellinwood.